State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

TO: ALL DENTAL PREPAID HEALTH PLANS
ALL DENTAL GEOGRAPHIC MANAGED CARE PLANS

DPIL 03-01 – CHANGES IN COVERED BENEFITS AS SET FORTH IN SBX1 26

The following should assist you in implementing changes in covered benefits for dates of service beginning July 1, 2003, as set forth in SBX1 26, amending Welfare and Institutions Code Section 14132.88. Please refer to Denti-Cal Bulletin, Volume 19, Number 12, dated May 2003. These changes do not apply to the Child Treatment Program or the County Medical Service Program.

Effective July 1, 2003, posterior laboratory processed crowns (procedures 650, 651, 652, 653, 660, and 663) are no longer a benefit for adults 21 years of age and older except when a posterior tooth is used as an abutment for any fixed or removable prosthesis with cast clasps and rests, and meets current criteria.

Prefabricated crowns for posterior teeth will remain a benefit. Beginning July 1, 2003, all services rendered for any prefabricated crown made from ADA-approved or certified materials that are used as a final restoration on posterior teeth will be reimbursed at the same rate as a stainless steel crown (**Procedures 670 and 671**). Please adjust your prices accordingly for your providers.

If you have questions or concerns regarding the above, please contact your contract manager or Ms. Cheri Gisler, Chief, Dental Managed Care Unit, at (916) 464-0375.

Sincerely,

Shelley A. Thomas, Chief
Medi-Cal Dental Services Branch

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
DIANA M. BONTÁ, R.N., Dr.P.H.
Director

ARNOLD SCHWARZENEGGER
Governor

December 16, 2003 FI # GDD-276

TO: ALL DENTAL GEOGRAPHIC MANAGED CARE PLANS

DPIL 03-02 - IMPLEMENTATION OF AB 1762

This Dental Policy Instruction Letter is to inform dental Geographic Managed Care plans of the impact of AB 1762, Chapter 230 (Statutes 2003). The bill, amongst other things impacts Medi-Cal dental services in two areas.

The bill directs the Department of Health Services (Department) to reduce program expenditures in Medi-Cal services by five percent. Specific to the dental Geographic Managed Care plans, the Department is statutorily obligated to reduce capitated rates by the actuarial equivalent of a five percent reduction effective January 1, 2004, which shall remain in effect until January 1, 2007. This reduction will be included as a part of the upcoming California Medical Assistance Commission rate negotiations.

With regard to Denti-Cal fee-for-service claims, the bill amends the Welfare and Institutions Code 14132.88(f) to require pretreatment radiograph documentation for post treatment claims to establish the medical necessity for dental restorations (fillings and prefabricated crowns). Additionally, pretreatment radiographic documentation for post treatment claims will be required only when there are four or more dental fillings being completed in any 12 - month period per beneficiary, and be required for all claims for prefabricated crowns.

To implement these changes on the fee-for-service side, dates of service beginning October 1, 2003, the Department will require the following:

- For procedure 670 (primary teeth) the radiograph must clearly demonstrate decay, fracture, or other damage involving three or more tooth surfaces; or two surfaces extending extensively buccolingually or mesiodistally; or submitted in conjunction with pulpal therapy on the same tooth.

- For procedure 671 (permanent teeth) the radiograph must clearly demonstrate traumatic or pathological destruction to the crown that is identical to the existing tooth type-specific criteria for laboratory-processed crowns; or that the stainless steel crown will restore an endondontically treated tooth.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 29 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 AUGUST 2003

REQUIRE DOCUMENTATION WITH CLAIMS FOR RESTORATIVE PROCEDURES PER AB 1762

Assembly Bill 1762, which was chaptered (became law) on August 11, 2003, has necessitated this revised bulletin that replaces the previous bulletin (July 2003, Volume 19, Number 21).

AB 1762 amends Welfare and Institutions (W&I) Code 14132.88(f) to require pretreatment radiograph documentation for post treatment claims to establish the medical necessity for dental restorations (fillings and prefabricated crowns) and to reduce fraudulent claims for unnecessary restorative services. In order to avoid any undue barriers to accessing dental care, pretreatment radiographic documentation for post treatment claims will be required only when there are four or more dental fillings being completed in any 12-month period, per beneficiary, and all claims for prefabricated crowns. Denti-Cal will review a subset of these claims using a computerized selection method.

For dates of services beginning October 1, 2003, the Department of Health Services will require the following:

- ✓ Pretreatment radiographic documentation for post treatment claims to establish the medical necessity for all ADA-approved prefabricated crowns (including stainless steel crowns).
  - For procedure 670 (primary teeth), the radiograph must clearly demonstrate decay, fracture, or other damage involving three or more tooth surfaces; or two surfaces extending extensively buccolingually or mesiodistally; or submitted in conjunction with pulpal therapy on the same tooth.
  - For procedure 671 (permanent teeth), the radiograph must clearly demonstrate traumatic or pathological destruction to the crown that is identical to the existing tooth type-specific criteria for laboratory-processed crowns; or that the stainless steel crown will restore an endondontically treated tooth.
- ✓ Medi-Cal Dental claims for restorative procedures (600, 601, 602, 603, 611, 612, 613, 614, 645, and 646) require submission of radiographs that clearly demonstrate that destruction to the tooth (decay, fracture, missing restorations, et cetera) extends through the dentinoenamel junction (DEJ). This submission requirement also applies to the replacement of existing restorations. The placing of restorations solely to replace tooth structure that was lost by attrition, abrasion or erosion, or solely for cosmetic purposes will continue to not be a benefit.

If dental radiographs are contraindicated for a particular patient, or if the submitted radiographs do not accurately depict the decay/destruction observed clinically, then providers should submit

Denti-Cal Bulletin (Volume 19, Number 29 dated August 2003) provides specific information regarding these changes, and is enclosed for your reference.

If you have any questions, please contact Mrs. Cheri Gisler, Chief, Dental Managed Care Unit at (916) 464-0375.

Sincerely,

for Shelley A. Thomas, Chief
Medi-Cal Dental Services Branch

Enclosure

intraoral photographs. The contraindication must be specifically documented. Intraoral photographs may be submitted with:

- ✓ Fiber Optic Transillumination
- ✓ DIAGNOdent Readings
- ✓ Caries Detection Dye
- ✓ Caries Risk Assessment
- ✓ Operating Room (O.R.) Report

Without photographic documentation augmented, if necessary, with the aforementioned clinical adjuncts used to diagnose caries, restorative services will be denied or modified when the submitted radiograph does not adequately show that the destruction penetrates the DEJ. The written statement "caries penetrates the DEJ" will no longer be considered adequate documentation for payment of a restoration. In addition, claims will be denied when necessary radiographs and/or photographs are not submitted. Should the claim be denied and/or exceptional circumstances exist, a Claim Inquiry Form (CIF) may be submitted for reconsideration.

Submitted radiographs and photographs must conform to the existing requirements and must be:

- ✓ Properly dated with the mm/dd/yy and labeled legibly with the patient's name as well as the Provider's name and Medi-Cal provider number. In order to enhance Denti-Cal's ability to return misplaced radiographs, it is recommended that providers also place the beneficiary's Social Security number or Benefits Identification Card number on the radiographs.
- ✓ Current: taken within the last 8 months for primary teeth and within the last 14 months for permanent teeth.
- ✓ Of diagnostic quality.
- ✓ Labeled "right" or "left."
- ✓ Radiographs in multiples of four or more must be mounted.

It is important that Denti-Cal Dental Consultants be able to correctly identify the area/arch/quadrant/tooth number(s) depicted in submitted intraoral photographs. If radiographs and/or photographs are NOT to be returned, indicate "do not return" on the envelope.

Providers who are currently using the Electronic Data Interchange (EDI) are encouraged to continue to use the EDI for procedure codes impacted by this bulletin. The documentation requirements as stated above apply to electronic claims, but radiographs, photographs and other clinical documentation DO NOT need to be mailed to Denti-Cal at the time the electronic claim is transmitted. Denti-Cal will select certain electronic claims using a computerized selection method and then request that the radiographs, photographs or attachments to support those claims be mailed. Electronic claims that are not selected will continue through the adjudication process. Providers who want to be considered for EDI should contact the Denti-Cal EDI Support Group at (916) 853-7373.

In the near future, a provider will be able to elect to submit a Treatment Authorization Request with restorative services listed, and include radiographs, photographs and other documentation. A bulletin will be forthcoming regarding this process.

California Schools of Dentistry participating in the University Pilot Project will continue to perform claims adjudication for their students in accordance with these program criteria.

For additional information please phone Denti-Cal toll-free at (800) 423-0507.

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
DIANA M. BONTÁ, R.N., Dr.P.H.
Director

ARNOLD SCHWARZENEGGER
Governor

December 22, 2003 GDD-279

TO: ALL DENTAL GEOGRAPHIC MANAGED CARE PLANS
ALL DENTAL PREPAID HEALTH PLANS

DPIL 03-03 – AB 999 ALTERNATIVES TO AMALGAM FILLINGS

This Dental Policy Instruction Letter (DPIL) is to inform Dental Managed Care Plans of the enactment and implementation of AB 999 (Statutes of 2003), which will become effective January 1, 2004. The Bill allows beneficiaries to elect to receive dental fillings that are alternatives to mercury-based fillings, and allows providers to receive the reimbursement rate for an amalgam restoration when using alternate dental restorative material. Accepted alternative materials are limited to composite resin, glass ionomer cement, and resin ionomer cement.

At this time, the Medi-Cal Dental Services Branch will not be establishing new procedure codes for alternate restorations. Fee-for-service providers are to use the following procedures when submitting claims for alternative restorative materials. For your information, a future Provider Bulletin will instruct fee-for-service providers to use the following procedures when submitting claims for alternative restorative materials.

- Use the appropriate amalgam restoration procedure code (Procedure 600 through 614, inclusive) on the Claim Services Line, along with the tooth number/letter and surfaces restored.

- Describe the restorative material used in Block 34 (Comments). In accordance with Welfare and Institutions Code Section 14132.22 (a), the accepted dental materials are limited to composite resin, glass ionomer cement, resin ionomer cement, and amalgam.

Please contact Cheri Gisler, Chief, Dental Managed Care Unit at (916) 464-0375 if you have any questions.

Sincerely,

Shelley A. Thomas, Chief
Medi-Cal Dental Services Branch

PAYMENT SYSTEMS DIVISION, P.O. BOX 997413, MS 4708, SACRAMENTO, CA 95899-7413
TELEPHONE: (916) 464-3888 FAX: (916) 464-0372
INTERNET ADDRESS: www.dhs.ca.gov

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

ARNOLD SCHWARZENEGGER
Governor

March 10, 2004

ALL DENTAL PREPAID HEALTH PLANS
ALL DENTAL GEOGRAPHIC MANAGED CARE PLANS

DPIL 04-01 REPORTING REQUIREMENTS, RELATING TO THE "IMPLEMENTATION OF SETTLEMENT IN THE DEPARINI v. BONTÁ CLASS ACTION DENTAL LAWSUIT"

Effective immediately, all Dental Managed Care Plans are no longer required to submit Deparini Quarterly Reports, (Denied Procedures by Adjustment Code) to the Medi-Cal Dental Services Branch. This was previously required in the Dental Policy Instruction Letter (DPIL), titled "Implementation of Settlement in the Deparini v. Bontá Class Action Dental Lawsuit" (refer to enclosure, page 8) dated November 16, 2001.

Although the quarterly reports are no longer necessary, all other requirements as stipulated in the above-referenced DPIL still apply.

If you have any questions or concerns regarding the above, you may contact your contract manager or Ms. Cheri Gisler, Chief, Dental Managed Care Unit, at (916) 464-0375.

Sincerely,

Shelley A. Thomas, Chief
Medi-Cal Dental Services Branch

Enclosure

PAYMENT SYSTEMS DIVISION, P.O. BOX 997413, MS 4708, SACRAMENTO, CA 95899-7413
TELEPHONE: (916) 464-3888 FAX: (916) 464-0372
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Pam

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

June 29, 2004

ALL DENTAL PREPAID HEALTH PLANS
ALL DENTAL GEOGRAPHIC MANAGED CARE PLANS

DPIL 04-02 – PROVISION OF DENTAL SERVICES TO CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

The purpose of this Dental Policy Instruction Letter (DPIL) is to provide clarification in the identification, coordination, and reporting of dental services for Children with Special Health Care Needs (CSHCN).

The CSHCN provisions are a result of the regulatory changes for Medicaid beneficiaries per the final rule of the Balanced Budget Act (BBA) of 1997, effective August 13, 2003. The CSHCN regulations were incorporated into both the Geographic Managed Care (GMC) and Prepaid Health Plan (PHP) contracts via the BBA Amendments under Article 7.5.3, CSHCN and Articles 2.80 (GMC) and 2.75 (PHP), definition of CSHCN.

Children with Special Health Care Needs (CSHCN) members can be defined, within the context of our dental GMC and PHP programs, as Medicaid children (up to age 21) who have or are at risk for chronic physical, behavioral, developmental, or emotional conditions that require medical support services for the provision of dental treatment.

Your dental network providers are responsible for deciding if an assigned/referred child member meets the above definition of CSHCN. The provider (usually the Primary Care Dentist (PCD)) should report these children to you shortly after the child's first dental encounter. Each dental plan is responsible for coordinating with the child's medical managed care plan for surgicenter or hospital operating room (OR) support services. If the child's PCD or specialist is not qualified to perform dental services in a surgicenter/OR setting, then the dental plan should reassign the CSHCN member to another dental provider who possesses the necessary credentials and privileges.

Dental plans should use their periodic Quality Management (Quarterly Aggregated Grievance) reports to notify the Medi-Cal Dental Services Branch of any complaints or grievances that pertain to CSHCN members.

If you have any questions, please contact Mrs. Cheri Gisler, Chief, Dental Managed Care Unit at (916) 464-0375 or your contract manager.

Sincerely,

Cheri Gisler for

Shelley A. Thomas, Chief
Medi-Cal Dental Services Branch

State of California—Health and Human Services Agency
Department of Health Services

California
Department of
Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

October 20, 2004

ALL DENTAL PREPAID HEALTH PLANS
ALL DENTAL GEOGRAPHIC MANAGED CARE PLANS

DPIL 04-03 – CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM SERVICES INFORMATION REGARDING THE RECOMMENDATION TO REFER CHILDREN TO A DENTIST BEGINNING AT ONE YEAR OF AGE

This Dental Policy Instruction Letter (DPIL) is to inform all Dental Managed Care Plans of the recent announcement of the new CHDP recommendation to refer children annually to a dentist beginning at one year of age, effective July 1, 2004. Enclosed for your review is the CHDP Provider Information Notice No. 04-13 sent to all County CHDP Program Directors, Deputy Directors, State Children's Medical Services Branch staff and regional office staff. Also included as enclosures are the following documents:

1) The American Academy of Pediatrics policy statement, "Oral Health Risk Assessment Timing and Establishment of the Dental Home;"

2) The revised Periodicity Schedule for Dental Referral by Age;

3) The revised PM 160 Dental Guide.

Please review and distribute this DPIL information and enclosures, without any changes, to dentists in your local provider network.

Additionally, please be prepared to assist members when a request is made for dental services by the Member, the Member's parent(s) or guardian, or through a county referral. As stated in Article 7.3 (2) of your Geographic Managed Care and Prepaid Health Plan contracts, an appointment will be made for the Member to be examined within three weeks of the request.

Medi-Cal Dental Services Branch, MS 4708, P.O. Box 997413, Sacramento, CA, 95899-7413
Telephone: (916) 464-3888 Fax: (916) 464-3783
Internet Address: www.dhs.ca.gov

Should your Dental Directors have any clinical questions on a case-by-case basis regarding a member, please have them contact Bryan Quattlebaum, D.D.S., Dental Consultant, Dental Managed Care Unit, at (916) 464-0374. All other questions should be directed to your contract manager.

Sincerely,

Shelley A. Thomas, Chief
Medi-Cal Dental Services Branch

Enclosures

State of California-Health and Human Services Agency
Department of Health Services

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

June 18, 2004

CHDP Program Letter No.: 04-13

TO: ALL COUNTY CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM DIRECTORS, DEPUTY DIRECTORS, STATE CHILDREN'S MEDICAL SERVICES (CMS) BRANCH STAFF AND REGIONAL OFFICE STAFF

SUBJECT: CHDP PROVIDER INFORMATION NOTICE NO.: 04-13 CHDP RECOMMENDATION TO REFER CHILDREN TO A DENTIST BEGINNING AT ONE YEAR OF AGE

Enclosed is the CHDP Provider Information Notice No.: 04-13 announcing the new CHDP recommendation to refer children annually to a dentist beginning at one year of age. Also included as enclosures are the following documents:

1) The American Academy of Pediatrics policy statement, "Oral Health Risk Assessment Timing and Establishment of the Dental Home;"

2) The revised Periodicity Schedule for Dental Referral by Age;

3) The revised PM 160 Dental Guide.

Please review and distribute this Provider Information Notice and enclosures, without any changes, to providers in your local program area and complete and return the enclosed "Report of Distribution."

Please be prepared to assist providers in locating dentists if they should have difficulty in making these referrals. If you have any questions, please contact your Regional Office Nurse Consultant.

Original signed by Marian Dalsey, M.D., M.P.H.

Marian Dalsey, M.D., M.P.H., Acting Chief
Children's Medical Services Branch

Enclosures

State of California-Health and Human Services Agency
Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

June 18, 2004

CHDP Provider Information Notice No.: 04-13

TO: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM PROVIDERS

SUBJECT: CHDP RECOMMENDATION OF DENTAL REFERRAL BEGINNING AT ONE YEAR OF AGE

The purpose of this notice is to inform providers of the new CHDP recommendation to begin referring children to a dentist at one year of age, and to provide changes to certain documents reflecting the new recommendation.

Background Information

Dental caries is the most prevalent infectious and chronic childhood disease (five times more prevalent than asthma). Early childhood caries (ECC) often starts as soon as the first tooth erupts, around 6 months of age. Studies show that more than one-third of children have dental caries by the time they reach kindergarten. ECC affects children in all racial and socioeconomic groups; however, there is a higher prevalence in children of low-income families, where it occurs in epidemic proportions.

In May of 2003, the American Academy of Pediatrics (AAP) released a Policy Statement, "Oral Health Risk Assessment Timing and Establishment of the Dental Home." In this Statement, the AAP discusses the transference of oral flora from the mother (or other caregiver) to the child, inoculating the child between 6 and 30 months with cariogenic organisms. To prevent caries in children, high-risk children and caregivers must be identified, preferably during prenatal care. Decreasing the level of cariogenic bacteria in the mother's oral flora can impact the child's predisposition to caries. Aggressive strategies for both the mother and the child should be adopted, including anticipatory guidance, behavior modification (oral hygiene and feeding practices) and the establishment of a dental home by one year of age. The complete policy statement is attached as Enclosure 1 or you may visit the AAP website: www.aap.org.

Another source of pertinent information for the health care provider is, "A Health Professional's Guide to Pediatric Oral Health Management" found at the National Maternal and Child Health website, www.mchoralhealth.org/PediatricOH/index.htm. This guide offers 7 modules for training health care providers to identify high-risk children, screen, offer anticipatory guidance and refer infants and young children to oral health professionals.

National dental and public health organizations also support a child's first dental visit by one year of age. These include the American Dental Association, American Academy of Pediatric Dentistry, American Public Health Association, Association of State and Territorial Dental Directors and statewide organizations such as California Dental Association, California Society of Pediatric Dentists, and the California Dental Hygienist's Association.

Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) statutes (Code of Federal Regulations, Title 42) governing the State CHDP program require the provision of dental services "at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care."

Change in Age Recommendation for Dental Referrals

Therefore, in accordance with the recommendation of the AAP and the above-mentioned national and statewide dental organizations, effective the date of this letter, the CHDP program recommends a direct referral to a dentist beginning at one year of age and annually thereafter. This recommendation does not change the regulatory mandate of a dental referral at three years of age.

If you are unable to locate a dentist to refer the child, please contact your local CHDP program for assistance.

The following documents have been revised to reflect the new recommendation. Relevant changes to the CHDP Provider Manual and Health Assessment Guidelines will be available at a later date.

1. Periodicity Schedule for Dental Referral by Age. (Enclosure 2)

2. The revised "PM 160 Dental Guide" is included, and can be downloaded from the CHDP website: www.dhs.ca.gov/chdp (Click on forms and publications) for its full color version. (Enclosure 3)

If you have any questions, please contact your local CHDP program.

Original signed by Marian Dalsey, M.D., M.P.H.

Marian Dalsey, M.D., M.P.H., Acting Chief
Children's Medical Services Branch

Enclosures

AMERICAN ACADEMY OF PEDIATRICS

POLICY STATEMENT

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Section on Pediatric Dentistry

Oral Health Risk Assessment Timing and Establishment of the Dental Home

ABSTRACT. Early childhood dental caries has been reported by the Centers for Disease Control and Prevention to be perhaps the most prevalent infectious disease of our nation's children. Early childhood dental caries occurs in all racial and socioeconomic groups; however, it tends to be more prevalent in low-income children, in whom it occurs in epidemic proportions. Dental caries results from an overgrowth of specific organisms that are a part of normally occurring human flora. Human dental flora is site specific, and an infant is not colonized until the eruption of the primary dentition at approximately 6 to 30 months of age. The most likely source of inoculation of an infant's dental flora is the mother or another intimate care provider, through shared utensils, etc. Decreasing the level of cariogenic organisms in the mother's dental flora at the time of colonization can significantly impact the child's predisposition to caries. To prevent caries in children, high-risk individuals must be identified at an early age (preferably high-risk mothers during prenatal care), and aggressive strategies should be adopted, including anticipatory guidance, behavior modifications (oral hygiene and feeding practices), and establishment of a dental home by 1 year of age for children deemed at risk.

INTRODUCTION

The Centers for Disease Control and Prevention reports that dental caries is perhaps the most prevalent of infectious diseases in our nation's children. Dental caries is 5 times more common than asthma and 7 times more common than hay fever in children.[1] More than 40% of children have tooth decay by the time they reach kindergarten.[2] Infants who are of low socioeconomic status, whose mothers have a low education level, and who consume sugary foods are 32 times more likely to have caries at the age of 3 years than children in whom those risk factors are not present.[3] Decay of primary teeth can affect children's growth, lead to malocclusion, and result in significant pain and potentially life-threatening swelling. Because pediatricians and other pediatric health care professionals are far more likely to encounter new mothers and infants than are dentists, it is essential that they be aware of the infectious pathophysiology and associated risk factors of early childhood dental caries to make appropriate decisions regarding timely and effective intervention. Dental decay can be well advanced by 3 years of age.

BACKGROUND

Dental caries results from an overgrowth of specific organisms that are part of normally occurring human dental flora.[4] *Streptococcus mutans* and *Lactobacillus* species are considered to be principal indicator organisms of those of aciduric bacteria responsible for caries. Human dental flora is site specific, and an infant is not colonized with normal dental flora until the eruption of the primary dentition at approximately 6 to 30 months of age.[5,6] The vertical colonization of *S mutans* from mother to infant is well documented.[7,8] In fact, genotypes of *S mutans* in infants appear identical to those present in mothers in approximately 71% of mother-infant pairs.[9] Furthermore, evidence suggests that specific organisms exhibit discrete windows of inoculation; the acquisition of *S mutans* occurs at an average age of approximately 2 years.[10]

The significance of this information becomes focused when considering 3 points. First, high caries rates run in families[11] and are passed from mother to child from generation to generation. The children of mothers with high caries rates are at a higher risk of decay.[12] Second, approximately 70% of all dental caries are found in 20% of our nation's children.[13] Third, the modification of the mother's dental flora at the time of the infant's colonization can significantly impact the child's caries rate.[14–16] Therefore, an oral health risk assessment before 1 year of age affords the opportunity to identify high-risk patients and to provide timely referral and intervention for the child and allows an invaluable opportunity to decrease the level of cariogenic organisms in the mother with a significant caries risk before and during colonization of the infant.

BASIC PREVENTIVE STRATEGIES

Historically, the approach to preventing the development of dental caries has been to establish and maintain good oral hygiene, optimize systemic and topical fluoride exposure, and eliminate prolonged exposure to simple sugars in the diet. The success of this age-old approach is also the foundation for the ideal standard of establishment of the dental home

by 1 year of age, as endorsed by the American Dental Association, the American Academy of Pediatric Dentistry, supporting organizations of Bright Futures, and numerous other children's health organizations.

Dental caries typically results from diet-mediated shifts in dental bacterial populations that favor acidogenic-aciduric (cariogenic) organisms.[17] The judicious optimization of diet, fluoride intake, and hygiene reverses the aciduric shift, resulting in fewer cariogenic flora and decreased rates of caries. Clinical observations suggest that aciduric shifts are often associated with pregnancy, with return to prepregnancy cariogenic-benign flora ratio occurring on the same timeline as the colonization of the infant with dental flora (6 to 30 months of age). The overall strategy is to lower the numbers of cariogenic bacteria in the mother's mouth and delay colonization as long as possible (avoid sharing of spoons, orally cleansing pacifiers, etc).

Tooth decay is a disease that is, by and large, preventable. Because of how it is caused and when it begins, however, steps to prevent it ideally should begin prenatally with pregnant women and continue with the mother and young child, beginning when the infant is approximately 6 months of age. The primary thrust of early risk assessment is to screen for parent-infant groups who are at risk of early childhood dental caries and would benefit from early aggressive intervention. The ultimate goal of early assessment is the timely delivery of educational information to populations at high risk of caries to avoid the need for later surgical intervention.

ORAL HEALTH RISK ASSESSMENT

Every child should begin to receive oral health risk assessments by 6 months of age by a qualified pediatrician or a qualified pediatric health care professional. The Caries Risk Assessment Tool (provided and continually updated by the American Academy of Pediatric Dentistry and available at http://www.aapd.org/members/referencemanual/pdfs/02-03/Caries%20Risk%20Assess.pdf) can be used to determine the relative risk of caries of the patient. In the case of the very young patient, a risk assessment to identify parents (usually mothers) and infants with a high predisposition to caries can easily be performed by taking a simple dental history from a new mother. Questions directed at dietary practices, fluoride exposure, oral hygiene, utilization of dental services, and the number and location of the mother's dental fillings can give a relative indication of the mother's baseline decay potential. Frequent sugar intake, low fluoride exposure, poor oral hygiene practices, infrequent utilization of dental services and/or active decay and/or multiple dental fillings in multiple quadrants of the mouth indicates a high caries risk in the mother. Because the dental history of the mother has a direct correlation to that of her infant, it is justifiable and appropriate for the pediatrician to garner permission to examine the mother's dentition and gingival tissues. Additionally, clinical observations suggest that second and third infants tend to be colonized earlier, when the mother's cariogenic flora is at a higher level. Therefore, the later-order offspring of a mother with mildly to moderately high caries rate may be at higher risk of caries than are offspring born earlier. Unfortunately, the lack of accessible longitudinal dental databases has not yet allowed these observations to be epidemiologically confirmed.

RISK GROUPS FOR DENTAL CARIES

The caries risk potential of an infant can be determined by the use of the Caries Risk Assessment Tool. However, even the most judiciously designed and implemented caries risk assessment tool can fail to identify all infants at risk of early childhood dental caries. If an infant is assessed to be within 1 of the following risk groups, the care requirements would be significant and surgically invasive; therefore, these infants should be referred to a dentist as early as 6 months of age and no later than 6 months after the first tooth erupts or 12 months of age (whichever comes first) for establishment of a dental home:

- Children with special health care needs
- Children of mothers with a high caries rate
- Children with demonstrable caries, plaque, demineralization, and/or staining
- Children who sleep with a bottle or breastfeed throughout the night
- Later-order offspring
- Children in families of low socioeconomic status

Despite all efforts to predict children at high risk of caries, patients can and do fall outside statistical expectations. In these cases, the mother may not be the colonization source of the child's dental flora, the dietary intake of simple carbohydrates may be extremely high, or other uncontrollable factors may combine to place the patient at risk of caries. Therefore, screening for risk of caries in the parent and patient coupled with oral health counseling, although a feasible and equitable approach to early childhood caries control, is not a substitute for early establishment of the dental home. Whenever possible, the ideal approach to early childhood caries prevention and management is the early establishment of a dental home.

ESTABLISHING THE DENTAL HOME

The concept of the "dental home" is derived from the American Academy of Pediatrics concept of the "medical home." The American Academy of Pediatrics states, "the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care."[18] Pediatric primary dental care needs to be delivered in a similar manner. The dental home is a specialized primary dental care provider within the philosophical complex of the medical home. Referring a child for an oral health examination by a dentist who provides care for infants and young children

6 months after the first tooth erupts or by 12 months of age establishes the child's dental home and provides an opportunity to implement preventive dental health habits that meet each child's unique needs and keep the child free from dental or oral disease. The dental home should be expected to provide:

- An accurate risk assessment for dental diseases and conditions
- An individualized preventive dental health program based on the risk assessment
- Anticipatory guidance about growth and development issues (ie, teething, digit or pacifier habits, and feeding practices)
- A plan for emergency dental trauma
- Information about proper care of the child's teeth and gingival tissues
- Information regarding proper nutrition and dietary practices
- Comprehensive dental care in accordance with accepted guidelines and periodicity schedules for pediatric dental health
- Referrals to other dental specialists, such as endodontists, oral surgeons, orthodontists, and periodontists, when care cannot be provided directly within the dental home

ANTICIPATORY GUIDANCE AND PARENT AND PATIENT EDUCATION

General anticipatory guidance for the mother (or other intimate caregiver) before and during the colonization process should include the following:

- Oral hygiene—the parent should be instructed to brush thoroughly twice daily (morning and evening) and to floss at least once every day.
- Diet—the parent should be instructed to consume fruit juices only at meals and to avoid all carbonated beverages during the first 30 months of the infant's life.
- Fluoride—the parent should be instructed to use a fluoride toothpaste approved by the American Dental Association and rinse every night with an alcohol-free over-the-counter mouth rinse with 0.05% sodium fluoride.
- Caries removal—parents should be referred to a dentist for an examination and restoration of all active decay as soon as feasible.
- Delay of colonization—mothers should be educated to prevent early colonization of dental flora in their infants by avoiding sharing of utensils (ie, shared spoons, cleaning a dropped pacifier with their saliva, etc).
- Xylitol chewing gums—recent evidence suggests that the use of xylitol chewing gum (4 pieces per day by mother) had a significant impact on decreasing the child's caries rates.[16]

General anticipatory guidance for the young patient (0 to 3 years of age) should include the following:

- Oral hygiene—the parent should begin to brush the child's teeth as soon as they erupt (twice daily, morning and evening) and floss between the child's teeth once every day as soon as teeth contact one another.
- Diet—after the eruption of the first teeth, the parent should provide fruit juices (not to exceed 1 cup per day) during meals only. Carbonated beverages should be excluded from the child's diet. Infants should not be placed in bed with a bottle containing anything other than water. Ideally, infants should have their mouths cleansed with a damp cloth after feedings.
- Fluoride—all children should have optimal exposure to topical and systemic fluoride. Caution should be exercised in the administration of all fluoride-containing products. The specific considerations of the judicious administration of fluoride should be reviewed and tailored to the unique needs of each patient. Review articles with applicable fluoride recommendations and supplementation algorithms are available.[19–22]

RECOMMENDATIONS

1. Early childhood caries is an infectious and preventable disease that is vertically transmitted from mothers or other intimate caregivers to infants. All health care professionals who serve mothers and infants should integrate parent and caregiver education into their practices that instruct effective methods of prevention of early childhood caries.
2. The infectious and transmissible nature of bacteria that cause early childhood caries and methods of oral health risk assessment, anticipatory guidance, and early intervention should be included in the curriculum of all pediatric medical residency programs and postgraduate continuing medical education curricula at an appropriate time.
3. Every child should begin to receive oral health risk assessments by 6 months of age from a pediatrician or a qualified pediatric health care professional.
4. Pediatricians, family practitioners, and pediatric nurse practitioners and physician assistants should be trained to perform an oral health risk assessment on all children beginning by 6 months of age to identify known risk factors for early childhood dental caries.
5. Infants identified as having significant risk of caries or assessed to be within 1 of the risk groups listed in this statement should be entered into an aggressive anticipatory guidance and intervention program provided by a dentist between 6 and 12 months of age.
6. Pediatricians should support the concept of the identification of a dental home as an ideal for all children in the early toddler years.

SUMMARY

Early childhood dental caries emerges within all cultural and economic pediatric populations; however, it approaches near epidemic proportions in populations with low socioeconomic status. Dental caries is an infectious disease usually passed from mother to child from generation to generation. Judicious optimization of diet, fluoride intake, and hy-

giene can decrease bacterial levels of specific organisms responsible for dental caries residing within normal dental flora. Decreasing the levels of cariogenic flora in the mother before and during the colonization process coupled with counseling directed toward optimal practices of diet, oral hygiene, and fluoride exposure can significantly and positively impact the child's predisposition to early childhood caries.

Pediatricians and pediatric health care professionals should develop the knowledge base to perform oral health risk assessments on all patients beginning at 6 months of age. Patients who have been determined to be at risk of development of dental caries or who fall into recognized risk groups should be directed to establish a dental home 6 months after the first tooth erupts or by 1 year of age (whichever comes first).

The ideal deterrence to early childhood caries is the establishment of the dental home when indicated by the unique needs of the child. Although not always feasible because of manpower and participation issues, best practice dictates that whenever feasible, all patients should have a comprehensive dental examination by a dentist in the early toddler years.

SECTION ON PEDIATRIC DENTISTRY, 2002–2003
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All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

PERIODICITY SCHEDULE FOR DENTAL REFERRAL BY AGE

Child Health and Disability Prevention (CHDP) Program

Age (Years)	1*	2*	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Interval to Next Referral	**1 Yr.**	**1 Yr.**	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.	1 Yr.
Annual Dental Referral	**X**	**X**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

*** Note:** A dental screening/oral assessment is required as part of every CHDP health assessment regardless of age. It is mandatory to refer children directly to a dentist annually beginning at age three (3). However, it is recommended that children be routinely referred to a dentist annually beginning at age one (1). Children of any age **must** be referred to a dentist if a problem is detected or suspected. For children covered by Medi-Cal or temporary Medi-Cal, call Denti-Cal, at 1-800-322-6384 or the local CHDP program for assistance in finding a dentist. All others may contact the local CHDP program for help.

Reference: California Code of Regulations, Title 17, Subchapter 13, CHDP, Section 6843.
Code of Federal Regulations, Title 42, Section 440.40 (b), Part 441, Subpart B.
CHDP Program Letter, 04-13

Date Revised June 2004

PM160 DENTAL GUIDE

CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM

Periodicity Schedule for Dental Referral by Age

Age (Years)	1*	2*	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Interval to Next Referral	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr
Annual Dental Referral	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

Children of any age **must** be referred to a dentist if a problem is detected or suspected. For children covered by Medi-Cal or temporary Medi-Cal, call Denti-Cal at 1-800-322-6384 or the local CHDP program for assistance in finding a dentist. All others may contact the local CHDP program for help.

***Note:** A dental screening/oral assessment is required as part of every CHDP health assessment regardless of age. It is recommended that children be referred to a dentist annually beginning at one (1) year of age. It is mandatory to refer children directly to a dentist annually beginning at three (3) years of age.

PM160 EXAMPLE

CHDP ASSESSMENT Indicate outcome for each Screening procedure	NO PROBLEM SUSPECTED ✓A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓B	PROBLEM SUSPECTED Enter Follow Up Code In Appropriate Column: NEW C	PROBLEM SUSPECTED Enter Follow Up Code In Appropriate Column: KNOWN D	DATE OF SERVICE Mo. Day Year: 01 / 15 / 97 FEES
01 HISTORY and PHYSICAL EXAM					
02 DENTAL ASSESSMENT/REFERRAL			5		
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION					
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					12
CODE	OTHER TESTS - PLEASE REFER TO THE CHDP LIST OF TEST CODES				CODE / OTHER TESTS

FOLLOW UP CODES
1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT RECHECK SCHEDULED.
3. DX MADE AND RX STARTED
4. DX PENDING/RETURN VISIT SCHEDULED
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX
6. REFERRAL REFUSED

REFERRED TO:	TELEPHONE NUMBER
M. Painless, DDS	(916)566-1233
REFERRED TO:	TELEPHONE NUMBER

COMMENTS/PROBLEMS
IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

02 - Class II - gingivitis and possible cavities

ROUTINE REFERRAL(S) (✓) ☐ BLOOD LEAD ☐ DENTAL	PATIENT IS A FOSTER CHILD (✓) ☐

ICD 9 CODES: 1 | 2 | 3

→ Routine Referral(s) (✓)

Enter a check mark in this box only when no dental problem is detected or suspected, and you have referred parents to a dentist to obtain any needed dental care. Annual dental referrals are recommended beginning at one (1) year of age and are mandatory beginning at three (3) years of age.

→ Follow-up codes for use in columns C and D

1) **NO DX/RX INDICATED OR NOW UNDER CARE: Enter code 1** if no treatment is indicated or the patient is now under care, e.g. dental problem now under care.
2) **REFERRED TO ANOTHER EXAMINER FOR DX/RX: Enter code 5** if a dental problem is suspected and enter name and telephone number of the dentist in the "Referred To" area.
3) **REFERRAL REFUSED: Enter code 6** if patient or responsible person refused referral or follow-up by examiner for any reason.

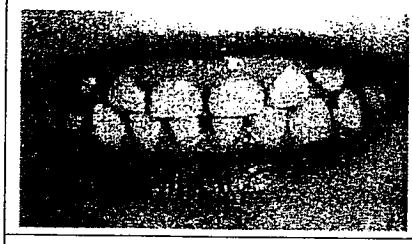
DENTAL CLASSIFICATIONS

The American Dental Association's "Classification of Treatment Needs" is a useful tool when referring children for dental services. If a problem is detected or suspected, on line 02 - "DENTAL ASSESSMENT/REFERRAL" enter code 5 in "Problem Suspected" columns C or D. In "Comments/Problems" section, describe the condition and classify using Class II, III, or IV. Enter name and phone number of dentist in the "Referred To" box.

CLASS I: NO VISIBLE DENTAL PROBLEM

No problem visualized. If child has not seen a dentist in the last 12 months - check box "Routine Referral-Dental".

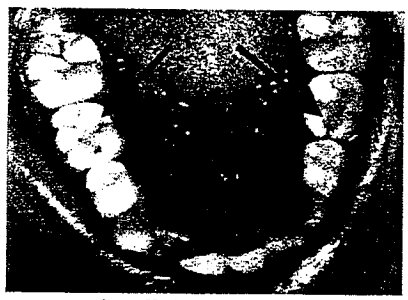
Annual referrals are recommended beginning at one (1) year of age and mandatory beginning at three (3) years of age.



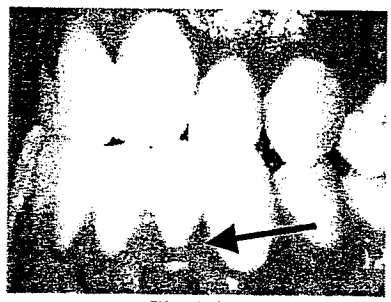
Appears Healthy But Needs Routine Referral

CLASS II: MILD DENTAL PROBLEMS

Small carious lesions or gingivitis and the patient is asymptomatic. The condition is not urgent, yet requires a dental referral. Write "02-Class II" in the "Comment/Problems" section of PM160.



Small Carious Lesion



Gingivitis

CLASS III: SEVERE DENTAL PROBLEMS

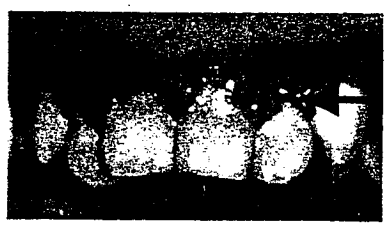
Large carious lesions, chronic abscess, extensive gingivitis, or a history of pain. The need for dental care is urgent. Refer for treatment as soon as possible. Write "02-Class III" in "Comments/Problems" section of PM160.

Large Carious Lesions

Chronic Abscess

If a severe (medically handicapping) malocclusion is detected or suspected, the child should be referred to a dentist. Write "02" in the "Comments/Problems" section of PM160 and indicate "severe malocclusion."

Early Childhood Caries (ECC)

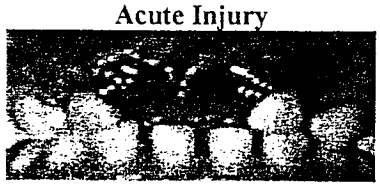


Extensive Gingivitis

CLASS IV: EMERGENCY DENTAL TREATMENT REQUIRED

Acute injury, oral infection, or other painful condition. An immediate dental referral is indicated. Write "02-Class IV" in the "Comments/Problems" section of PM160.

Acute Injury



Oral Infection

4/28/04

State of California—Health and Human Services Agency
Department of Health Services

California
Department of
Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

March 16, 2005

TO: ALL DENTAL PREPAID HEALTH PLANS
ALL DENTAL GEOGRAPHIC MANAGED CARE PLANS

SUBJECT: DPIL 05-01 – NEW "MAXIMUS" ENROLLMENT/DISENROLLMENT DATA REPORTING CHANGES

This Dental Policy Instruction Letter (DPIL) is to inform the Dental Managed Care Plans (DMCPs) of the implementation of MAXIMUS' new electronic reporting process for Enrollment/Disenrollment data. The Secure Website System (SWS) will replace the current method of transmitting data via the Bulletin Board System (BBS) and the diskette-mailing process. The SWS will increase the security and confidentiality of the beneficiary information transmitted to DMCPs. The site utilizes 128-bit SSL encryption. Website access is monitored and audited for security purposes and Health Insurance Portability and Accountability Act (HIPPA) compliance.

The SWS will be available beginning 30 days from the date of this letter. To ensure that the Plans have sufficient time to adjust their internal processes, the BBS and diskette transmittal process will continue for an additional 30 days (for a total of 60 days from the date of this letter). Weekly enrollment/disenrollment data that the DMCPs currently receive will be posted to a folder dedicated to each Plan at 8:00 A. M., and will be available for four weeks (see BBS/Diskette schedule for posting dates). The Summary and Detail files will no longer be placed in each folder in their native format. They will be in the format and utilize file-naming conventions currently used for the BBS as follows:

S: Summary
mm: 2 digit month
yy: 2 digit year

T: Transaction Detail (Totals)
dd: 2 digit date
ppp: 3 digit plan number

For example, if the DMCP number is 123, and the files are for July 23, 2004, the two files placed in the folder would be named S_072304.123 and T_072304.123 respectively.

In addition to the weekly files, each DMCP will have access to a "Reference Materials" folder. The folder contains:

- The "MAXIMUS Secure Web Services Site: Managed Care Plan User Guide"
- The most current file format specifications
- The Health Care Options Managed Care Plan Data File Posting Schedule (currently the same as the BBS/diskette schedule)
- The MAXIMUS "Secure Website Managed Care Plan Agreement Form" (Appendix "A", page 22)

At this time, DMCPs are asked to review the enclosures outlining the action that needs to occur in order to receive data through the Secure Website. Each DMCP must complete and return the enclosed "Maximus Secure Website Managed Care Plan Agreement Form" to begin using the SWS. The completed form should be returned to MAXIMUS within 30 days of the date of this letter.

Any questions you may have regarding this DPIL should be addressed to your Dental Contract Manager.

Sincerely,

Maria Enriquez, Chief
Medi-Cal Dental Services Branch

Enclosures: Managed Care Plan User Guide
Plan Agreement Form
Return Envelope for the MAXIMUS Secure Website Managed Care